THE STATE OF DELAWARE

DL-4: Authorization to Release Information for Solicitation Purposes

To be completed by employee seeking leave donations from other employees

Name (Last, First, MI) _____

Agency _____ Date of Hire _____

Illness* of (check one) [ ] Employee [ ] Employee's Family Member

If employee's Family Member: Relationship to employee _____

Name of Family Member _____

Family Member's present address _____

How long has the Family Member been a resident at the present address? _____

Date of accident or beginning of sickness _____

Date you became unable to work _____

Date you plan to return to work _____

Briefly describe the nature of the illness/injury: _____

_____

Date all Sick Leave will be/was exhausted	Date one-half Annual Leave will be/was exhausted	Date all Annual Leave will be/was exhausted
_____	_____	_____

Other Sources of Income Continuation (complete the following information where applicable; otherwise, indicate "not applicable" or "not eligible.")

	Number Hours	Benefit Amount	Date Payment Begins	Date Payment Ended
State Retirement/Disability Pension	_____	_____	_____	_____
Pay Pending Disability Pension Determination	_____	_____	_____	_____
Compensatory Time	_____	_____	_____	_____
Social Security	_____	_____	_____	_____
Private Disability Income Insurance	_____	_____	_____	_____
Workers' Compensation	_____	_____	_____	_____
Worker's Compensation Supplement Pay	_____	_____	_____	_____
Leave Donations from Spouse or Other Relatives	_____	_____	_____	_____
Any Other Income Sources	_____	_____	_____	_____

I understand that leave donations will be normally solicited in the following order. My agency or department will determine the actual order of the solicitation based upon the information provided. Please provide the information requested and any other suggestions you may have for soliciting leave donations.

1. The employees listed below with whom I have already spoken to concerning a donation. (Recipient should provide each employee with a DL-2: Request to Make a Direct Donation.)

Employee Name	Agency	Work Location	SLC

2. My current work unit is: _____

3. My current work facility (e.g., Stockley Center) is: _____

4. Any prior work unit. My previous work units were:

Work Unit	Agency	Location

5. My current division (e.g., Public Health, Motor Vehicle) is: _____

6. My department or agency (e.g., Correction, DHSS) is: _____

7. Other specific departments or agencies that I interact with in my job or would be a good source for donations for other reasons. Please indicate any specific departments or agencies: _____

8. Statewide Solicitation

I hereby authorize release of the information indicated above to solicit hours on my behalf under the State of Delaware Donated Leave Program. I understand that this information will be shared with employees requesting information in connection with my request for leave donations.

_____ _____

Employee Signature Date

Upon completion, please forward to applicant's agency personnel/payroll office.

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*